MEDICARE PHYSICIAN RESOURCE USE MEASUREMENT AND REPORTING PROGRAM

PHASE II UPDATE

February 19, 2010

Phase I of the Physician Resource Use Measurement and Reporting (RUR) Program was completed in 2009 with approximately 310 reports being sent to randomly selected physicians in 12 metropolitan areas across the United States. Formative testing of the reports with physicians, as well as retrospective analyses of the data used in Phase I has informed CMS' plans for Phase II of the RUR Program. As indicated in the Medicare Physician Fee Schedule Final Rule (74 FR 61844), Phase II will expand the program to include providing reports to groups of physicians, as well as the individual practitioners affiliated with those groups. Phase II reports will include clinical quality data, in addition to the resource use information. In contrast to Phase I, however, Phase II reports will focus only on per capita resource use measurement. CMS will not use proprietary episode groupers to provide episode-based resource measurements, but instead will provide condition-specific per capita resource use information for five high-cost, high-volume conditions.

Phase II, which is currently in development, will consist of two waves of report dissemination activity. First, in late summer or early fall 2010, CMS plans to distribute reports to a small number of selected groups in the same 12 metropolitan areas that were used in Phase I. CMS also plans to distribute reports to the practitioners affiliated with those groups. We are defining groups and their affiliated practitioners using Tax Identification Numbers (TINs) and National Provider Identifiers (NPIs). These reports will contain both cost and quality data, and be distributed through an electronic mechanism i.e., the Physician Quality Reporting Initiative (PQRI) portal and e-mails to individual providers. The focus of this first wave is to assess our ability to accurately identify groups and their affiliated practitioners, and test how well the electronic report distribution mechanism works. With the assistance of our support contractor, we will garner feedback, document, and analyze our processes, as we did in Phase I.

Second, beginning in early 2011 and continuing through the year toward eventual report distribution in late 2011 or early 2012, CMS plans to undertake a significant effort to involve and engage stakeholders in creating composite cost and quality scores. CMS hopes that this work will inform continued development toward creation of value scores. Proposed health care reform legislation portends CMS being able to pay differentially based on the value of care provided. We understand the potential impact this has on the many Medicare practitioners who provide care to our beneficiaries, and, therefore, we are seeking to emphasize the collaborative nature of this process. Plans include involving both internal and external stakeholders, a public listening session, outreach through the American Medical Association and medical specialty societies, and e-mail communications. We will continue to discuss our proposals and accept public comment through the Medicare Physician Fee Schedule rulemaking process.